Charm Behavioral Health Services
Medical Information Release Form

Patient Name:____________________________ Patient DOB:___________________________

Please complete all sections of this Medical Information Release Form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Please initial below to give permission for Charm Behavioral Health Services to share all notes acquired in counseling sessions including, but not limited to, diagnoses, treatment and billing records with ____ personnel and associated medical practitioners.

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Please initial below to give permission for Charm Behavioral Health Services to send an electronic copy of notes or access via a web-based platform aforementioned personnel and associated medical practitioners.

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Please initial below to confirm that this authorization to share above mentioned health information is valid from the date signed below until the time that counseling is no longer needed or wanted by the client.

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Please initial below to confirm that you understand you are permitted to revoke this authorization to shared above mentioned health data at any time and can do so by submitting a request to info@charmbehavioral.com

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Please initial below to confirm that you understand that in the event that information has already been shared by the time authorization is revoked, it may be too late to cancel permission to share the health data, that I do not need to give any further permission for the information detailed above to be shared with the person(s) or organization(s) listed, and that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent the reception of treatment or benefits the client is entitled to receive, provided this information is not required to determine eligibility to receive those treatments or benefits or to pay for the services I receive.

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Please sign below to confirm that you have filled this form to the best of your ability and that you are legally authorized to give permission for sharing medical documents on behalf of the client.

Patient or Authorized Individual Signature: ______________________________________

Printed Name: ____________________________________

Relationship to Patient:_____________________________________

Date: __________________________________

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